FORM APPROVED OMB NO. 0938-0008

Portable X-Ray Services

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

MEDICARE		DICAID [CHAMPUS	CHAMPVA		7				
(MEDICARE NO.)		EDICAID NO.)	(SPONSOR'S SSN)	(VA FILE NO.)		FECA BLACK LUP (SSN)	4 G		OTHER CERTIFICATE SSNI	
1. PATIENT'S NAME (LAST I	NAME FIRST		AL) 2. PATIENT'S DATE				NAME EI	RST NAI	ME, MIDDLE INITIAL)	
Recipient	Im		MM DD	YY	1 -	ame		151 144	ore, middle mirrae,	
4. PATIENT'S ADDRESS (ST			5. PATIENT'S SEX	1 21	6. INSUF	ED'S I.D. NO. (FOR	PROGRAM	A CHECI	KED ABOVE,	
600 11117			MALE V	INCLUDE ALL LETTERS)						
609 Willow			<u></u>				123456789Ø			
Anytown WI	53725		7 PATIENT'S RELATIONSH	7 PATIENT'S RELATIONSHIP TO INSURED 8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)				M NO.1		
·			SELF SPOUS	CHILD OTH	IER					
TELEPHONE NO.			X			INSURED IS EI	MPLOYED AND	COVERED	BY EMPLOYER	
9 OTHER HEALTH INSURANCE COVE PLAN NAME AND ADDRESS AND	RAGE (ENTER N	AME OF POLICYHOLDER AND	10 WAS CONDITION RELI	TED TO:	11. INSURED	11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)				
			A. PATIENT'S EMPLOYMEN	т						
OI - D			YES	YES X NO						
					TELEPHO	INE NO.				
			8. ACCIDENT		11.0		MPUS SPONS			
			AUTO	AUTO X OTHER			STATUS DECEASED BRANCH OF SERVICE			
12. PATIENT'S OR AUTHORIZED PERS	ON'S SIGNATUR	E MEAN BACK BEFORE CICAM	A/C:				13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED			
AUTHORIZE THE RELEASE OF A	FORMATION NECESSARY TO P	PROCESS THIS CLAIM, I ALSO REQUEST PA	YMENT	13. I AUTHO PHYSICI	AN OR SUPPLIER FOR SE	RVICE DESCR	IBED BELO	W.		
1111	, , ,	, , , , , ,	111111		1,,	, , , , ,	, ,	, ,		
SIGNED / / / /	, , ,	<i>, , , , , ,</i> ,	/ / / / / DATE /	/ / / / / /		RED OR AUTHORIZED/P	ERSON) /	/ /		
14. DATE OF:	ILLNESS (FIRST SYMPTOM) OR INJUR		PLIER INFORM		NT HAS HAD SAME (ne	116	i.a. IF EMERGENCY	
	CONDITION			R ILLNESS OR INJURY		, "	CHECK HERE			
17. DATE PATIENT ABLE TO	18. DATE	S OF TOTAL DISABILITY				DATES OF PARTIAL DISABILITY				
RETURN TO WORK	1-4.1	11111	////////////////////////////////////	11111	, ,	1 1 1 1 1	/ 1	,		
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (42, PUBLIC HEALTH AGENCY)						FROM / / / THROUGH / / / 20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE				
I. M.	RING 123	45678	HOSPITALIZATION DATES							
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)						ADMITTED DISCHARGED 22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?				
					YES	NO CHAI	RGES:			
23 A DIAGNOSIS OR NATURE O ETC. OR DX CODE ———	F ILLNESS OR	NJURY, RELATE DIAGNOSIS	S TO PROCEDURE IN COLUMN D BY RE	FERENCE NUMBERS 1, 2, 3		B				
' V725						EPSDT		YES	X NO	
2			1	FAMILY PLANNING YES X NO						
3.					+	PRIOR			=======================================	
4		T			•	AUTHORIZATION N	0.			
DATE OF SERVICE	PLACE OF	FURNISHED FOR EACH PROCEDURE CODE	CEDURES, MEDICAL SERVICES OR SUI H DATE GIVEN	PLIES	D.	_	F. DAYS		H. LEAVE BLANK	
FROM TO	SERVICE	(IDENTIFY)	(EXPLAIN UNUSUAL SERVICES O		DIAGNOSIS CODE	CHARGES	UNITS	G. * T.O.S.		
02/21/88	4	R0070	Transp. of p	ort	7	vvvv	ח ד	4		
	<u> </u>	2.000	X-ray equip.			XXXX	1.0	4		
02/21/88	4	R0.075-Z2	X-ray out	of zone	1	xxxx	1.0	4		
			pick-up			AAAA	1.0			
02/21/88	4	72010	Radiologic examentire, antepos		1	XX XX	1.0	4		
			entile, antepos	sterior		+				
· · · · · · · · · · · · · · · · · · ·	 					 	-			
	į									
						 			Patient	
		ĺ							Spenddown	
25 SIGNATURE OF PHYSICIAN O CREDENTIALS) (I CERTIFY TH	AT THE STATE	MENTS ON THE REVERSE A	PPLY TO 26. ACCEPT ASSIGNME	NT (GOVERNMENT BACK)	27. TOTAL	CHARGE	28. AMOI	UNT PAID		
THIS BILL AND ARE MADE A				XX XX XX XX XX.XX						
			/ / / es //	/ [Nd /	31. PHYSIC AND T	IAN'S, SUPPLIER'S, AN	D/OR GROU	P NAME.	ADDRESS, ZIP CODE	
			30. YOUR SOCIAL SECU	JRITY NO.	1 _					
10/ mm /577 T	· M TV	Ottom			I.M. Billing					
DATE: MM/DD/YY]		CO ∧ TDFK		1 W Williams						
32. YOUR PATIENT'S ACCOUNT NO. 33. YOUR EMPLOYER I.D. NO. 1.D. No. Anytown WI 53725 1234JED										
17777777777										
	E SERVICE TO	IC I CODER ON THE BACK								
REMARKS:	F SERVICE (T.C	AS.) CODES ON THE BACK		Y AMA COUNCIL L SERVICE 6/83		HCFA-1500 (84) F	orm OWCP-1500 Form RRB-1500	